Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $7,374.00 for dates of service 06/04/01 through 12/21/01.

   b. The request was received on 05/07/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 06/04/02
   b. HCFA(s)
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/13/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 06/17/02. The response from the insurance carrier was received in the Division on 07/01/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request.

3. Notice of Additional Information submitted by the Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated June 4, 2002 that…

   … "Carrier denies payment as 'N' and the description put down by carrier says 'denied per peer review.' This is improper coding. TWCC rule 133.304(c) says, 'A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section.' Carrier's description has nothing to do with the 'N' code they put. It is for the 'V' code. Improper coding by carrier is won by provider at SOAH and should be won at MDR if the reviewer reads TWCC 133.304 rules. Providers lose all the time on technicalities and so should the carrier. This rule is in place forcing the carrier to identify to the provider what has not been documented."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 06/04/01 and extending through 12/21/01.

2. The denial code listed on the EOBs is "N-Not Documented-TWCC 62 DISPUTED PER PEER REVIEW."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
06/04/01 06/05/01 06/06/01 06/07/01 06/12/01	97110	$105.00 $105.00 $105.00 $105.00 $105.00	$0.00 $0.00 $0.00 $0.00 $0.00	No EOBs No EOBs No EOBs No EOBs No EOBs	$35.00	MFG MGR (I)(A)(10) CPT descriptor TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." The provider billed CPT code 97110 in accordance with the Fee Guidelines. "Procedures (Supervision by the doctor or HCP, in either a group (97150) or one-to-one (97110-97139) setting is required." The notes are descriptive of modalities performed, length of procedures, and response from injured worker on how the therapy session helped the claimant. However, the SOAP notes do not support any clinical (mental or physical) reason as to why the patient could not have performed his exercises in a group setting, with supervision, as opposed to one-to-one therapy. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution Division indicate overall deficiencies in the adequacy of the documentation of this code. The disputes indicate confusion regarding what constitutes "one-on-one." The Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation and concludes, there is insufficient documentation to allow reimbursement beyond one unit on each date of service. Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended in the amount of **$175.00**. ($35.00 x 5)

06/05/01 06/06/01 06/07/01 06/12/01	99213-MP	$48.00 $48.00 $48.00 $48.00	$0.00 $0.00 $0.00 $0.00	No EOBs No EOBs No EOBs No EOBs	$48.00	MFG E/M GR (IV)(C)(2) CPT descriptor TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." **"...TWO OF THE THREE KEY COMPONENTS** (as set out in the descriptors) shall meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; ..." " Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the three key components: an expanded problem focused history; an expanded problem focused examination; medical decision of low complexity." Medical documentation indicates that the services were rendered and billed according to the referenced rule and CPT descriptor. Therefore, reimbursement is recommended in the amount of **$198.00.**
08/04/01 09/06/01 09/13/01 09/20/01 09/28/01 10/04/01 10/24/01 10/31/01 11/08/01 11/16/01 11/21/01 11/28/01 12/14/01 12/14/01 12/21/01	99213	$48.00 $48.00 $48.00 $48.00 $48.00 $48.00 $48.00 $48.00 $48.00 $48.00 $48.00 $48.00 $48.00 $48.00 $48.00	$0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00	N N N N N N N N N N N N N N N	$48.00	MFG E/M GR (IV)(C)(2) CPT descriptor TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." **"...TWO OF THE THREE KEY COMPONENTS** (as set out in the descriptors) shall meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; ..." " Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the three key components: an expanded problem focused history; an expanded problem focused examination; medical decision of low complexity." Medical documentation indicates that the services were rendered and billed according to the referenced rule and CPT descriptor. Therefore, reimbursement is recommended in the amount of **$720.00.**
06/05/01 06/06/01 06/07/01 06/12/01	97265	$43.00 $43.00 $43.00 $43.00	$0.00 $0.00 $0.00 $0.00	No EOBs No EOBs No EOBs No EOBs	$43.00	MGR (I)(A)(10); CPT Descriptor TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended in the amount of **$172.00**.
06/05/01 06/06/01 06/07/01 06/12/01	97122	$35.00 $35.00 $35.00 $35.00	$0.00 $0.00 $0.00 $0.00	No EOBs No EOBs No EOBs No EOBs	$35.00	MGR (I)(A)(10); CPT Descriptor TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended in the amount of **$140.00**.

06/05/01 06/06/01 06/07/01 06/12/01	97250-59	$43.00 $43.00 $43.00 $43.00	$0.00 $0.00 $0.00 $0.00	No EOBs No EOBs No EOBs No EOBs	$43.00	MGR (I)(A)(10); CPT Descriptor TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended in the amount of **$172.00**.
06/05/01 06/06/01 06/07/01 06/12/01	97032	$44.00 $44.00 $44.00 $44.00	$0.00 $0.00 $0.00 $0.00	No EOBs No EOBs No EOBs No EOBs	$22.00	MFG MGR (I)(A)(10) CPT descriptor TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended in the amount of **$176.00**.
06/07/01 08/14/01 11/21/01	97750-MT	$43.00 $43.00 $43.00	$0.00 $0.00 $0.00	No EOBs N N	$43.00 (each 15 minutes)	MFG E/M (IV)(A)(1) CPT descriptor TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." According to the referenced Rule: "When the doctor performs a complete diagnostic service during an office visit (e.g, technical and professional component of a study), both components of the service shall be reimbursed in addition to the office visit." The documentation indicates that the services were rendered. Therefore, reimbursement is recommended in the amount of **$129.00**.
06/12/01 11/21/01	95851	$36.00 $36.00	$0.00 $0.00	No EOBs N	$36.00	MFG MGR (I)((E)(3) TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended in the amount of **$72.00**.
06/07/01 06/12/01 11/21/01	99090	$108.00 $108.00 $108.00	$0.00 $0.00 $0.00	No EOBs No EOBs N	$108.00	CPT descriptor TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." CPT descriptor states: "Analysis of information data stored in computers (eg, ECGs, blood pressures, hematologic data)." According to the CPT descriptor, the DOS in dispute 06/07/01, 06/12/01, and 11/21/01 the documentation in the case file does support the services were rendered. Therefore, reimbursement **is** recommended in the amount of **$324.00.**

08/28/01 10/18/01	97750-FC	$200.00 $200.00	$0.00 $0.00	N N	$100.00 (per hour)	MFG MGR (I)(2) TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." "FCEs are allowed a maximum of three times for each injured worker. FCEs shall be billed as code 97750-FC. FCEs shall be reimbursed at $100.00 per hour for a maximum of five hours ($500) for the initial test and two hours ($200) for an interim and/or discharge test. A summary report for each FCE is required and shall not be reimbursed in addition to the evaluation charge. Required documentation includes the start and end time for the FCE." Medical documentation indicates that the services were rendered and billed according to the referenced rule. Therefore, reimbursement is recommended in the amount of **$400.00**.
07/27/01 08/01/01 08/03/01 08/27/01 08/28/01 08/29/01 10/08/01 10/10/01 10/11/01 10/12/01 10/15/01 10/16/01 10/18/01 10/22/01 10/23/01	97545-WH	$102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40 $102.40	$51.20 $51.20 $51.20 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00	N N N N N N N N N N N N N N N	$64.00 (per hour)	MFG MGR (II)(E)(3-8) CPT descriptor TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." The provider is a non-CARF accredited facility. Documentation submitted by the provider indicates that the services were rendered. The provider billed according to TWCC Rules. Therefore, reimbursement **is** recommended in the amount of **$1,382.40.**
08/27/01 08/28/01 08/29/01 10/08/01 10/10/01 10/11/01 10/12/01 10/15/01 10/16/01 10/18/01 10/22/01 10/23/01	97546-WH	$256.00 $204.80 $204.80 $256.00 $153.60 $307.20 $256.00 $307.20 $307.20 $256.00 $307.20 $153.60	$0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00	N N N N N N N N N N N N	$64.00 (per hour)	MFG MGR (II)(E)(3-8) CPT descriptor TWCC Rule 133.304(c)	TWCC rule 133.304(c) says, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." The provider is a non-CARF accredited facility. Documentation submitted by the provider indicates that the services were rendered. The provider billed according to TWCC Rules. Therefore, reimbursement **is** recommended in the amount of **$2,969.60.**
Totals		$7,527.60	$153.60				The Requestor **is** entitled to reimbursement in the amount of **$7,030.00.**

The above Findings and Decision are hereby issued this 24th day of October 2002.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $7,030.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 24th day of October 2002.

Carolyn Ollar
Supervisor Medical Dispute Resolution
Medical Review Division

CO/mb